TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Continental Casualty Co

MFDR Tracking Number
M4-16-0792-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills have been denied by the carrier bills are on wrong claim form. We are a pharmacy and our bills are on the correct form."

Amount in Dispute: $826.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: December 29, 2015: "The carrier has reconsidered the bills for the above mentioned dates of service and is processing them for payment."

Response Submitted by: Broadspire, P.O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2015	Pharmacy Services	$826.58	$826.58

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out billing requirements for pharmacy services.
3. 28 Texas Administrative Code §134.503 sets out the requirements for pharmacy services.
4. Neither party submitted an explanation of benefits for the services in dispute. However copies of a document titled, "Provider Request Letter" with the dates July 9, 2015, August 12, 2015 and August 31, 2015. With "Comments," Bill not submitted on required standard form – Please resubmit on State specific billing forms."

Issues

1. Was the correct form used to submit the services in dispute?
2. What is the applicable rule pertaining to reimbursement of the services in dispute?
3. Is the requestor due additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.10 (c) states in relevant part, "(c) Pharmacists and pharmacy processing agents shall submit bills using the Division form DWC-066." Review of the submitted documents finds for DWC066 was used to submit the claims with date of service June 15, 2015. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.
2. This case concerns the prescription of compound drugs. 28 Texas Administrative Code §134.503 (c) states in relevant part,

> The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
>
> (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
>
> (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

Pursuant to provisions of Rule 134.503(c)(1), the maximum allowable reimbursement will be calculated as follows:

Date of service	Name of Medication	Reported units	MAR (AWP per unit) x (number of units) x 1.25 + $4.00
June 15, 2015	Meloxicam	60	4.84490 x 60 x 1.25 + $4.00 = $367.37
June 15, 2015	Tramadol (Bulk Powder)	60	36.30000 x 60 x 1.25 + $4.00 = $2,726.50
		Total	$3,093.87

3. Based on the submitted DWC066, Box 21, the Generic NDC is for Tramadol, **bulk powder**, and box 23 shows 60 units. The total allowed amount based on NDC number submitted and total number of units is $3,093.87. The requestor is seeking $826.58, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $826.58.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $826.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.